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ABSTRACT

This publication shows gains and losses for health education in Missouri's public schools. Data come from the School Health Education Profile, a survey that monitors the status of health education in public schools, including education to prevent HIV infection and other important health problems, at the middle, junior, and senior high school levels. During the spring of 1998, questionnaires were sent to principals and lead health educators at 420 secondary schools. Usable questionnaires were received from 313 principals and 317 teachers. Results are presented according to school support for health education, teacher preparation, amount of classroom instruction, content of classroom instruction, and parent and community involvement. Positive changes included increases in: the number of schools with a designated coordinator of health education, community representation on school health advisory boards, and the amount of health education required. Negative changes included decreases in: school support for inservice training in health education, the number of school health advisory councils, and the amount of HIV/AIDS education. The study found that health education teachers have become less experienced, feedback from parents tends to result in more health education, and teaching of health-enhancing skills remains high. Three appendixes present the Missouri School Improvement Standards on Health Education and Communicable Diseases, policy guidelines on communicable diseases, and infection control procedures for schools. (SM)

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1998 Missouri School Health Education Profile

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Missouri Department of Elementary and Secondary Education
Robert E. Bartman, Commissioner of Education

SP038943

1998 Missouri School Health Education Profile

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Summary

The 1998 Missouri School Health Education Profile shows both gains and losses for health education in Missouri's public schools. The overall quality of health education remains far better than in 1994, when the first School Health Education Profile was administered. However, the 1996 profile documented tremendous gains for health education in most areas. The 1998 profile shows declines in many indicators since 1996.

Positive changes documented by the 1998 survey include:

- An increase in the number of schools with a designated coordinator of health education
- An increase in community representation on school health advisory councils
- An increase in the amount of health education required

Negative changes documented by the 1998 survey include:

- A decrease in school support for in-service training in health education
- A continuing decrease in the number of school health advisory councils
- A decrease in the amount of HIV/AIDS education, including basic facts about the disease, sexual behaviors that transmit HIV, condom use, and reasons for choosing sexual abstinence

Other important findings from the survey include:

- Health education teachers have become less experienced.
- Feedback from parents tends to result in more health education, rather than less, even on such controversial topics as pregnancy prevention, sexuality, and HIV/AIDS prevention.
- Teaching of health-enhancing skills remains high.

Significant Findings

One of the most troubling findings is the decrease in the amount of HIV/AIDS education. A smaller percentage of Missouri high school students communicated with parents or caregivers on the subject of HIV/AIDS in 1997 than in 1995, according to the *1997 Missouri Youth Risk Behavior Survey*, a self-reported survey administered every other year in randomly selected 9th through 12th grades. In addition, that survey showed that a higher percentage of students was abstaining from sex, that students who had sex were doing so less often, and that they were using condoms more often. If high school students in Missouri have been engaging in healthier behavior as a result of health education at school, it is unfortunate that schools appear to be decreasing the amount of HIV/AIDS education.

When health education teachers were asked to list obstacles to teaching about HIV/AIDS, they indicated that

parental opposition increased in 1996 and increased again in 1998 (see Table 6). But when the same teachers were asked whether feedback from parents had resulted in their teaching more or less about various topics, they reported that parental feedback resulted in more education about all topics concerned with sexuality, including HIV prevention (see Table 9). The distinction shows the value of engaging parents, a process which can be facilitated through a school health advisory council.

Recommendations

Recommendations based on the findings of the *1998 Missouri School Health Education Profile* include:

- Schools should increase financial support for health education teachers to obtain in-service training, which is essential in a field that changes so rapidly.
- Schools should establish or revive school health advisory councils with representation from parents, the local health department, the local medical society, students, minority groups, religious organizations, and other relevant groups to help formulate a policy on HIV/AIDS education.
- Schools should continue to teach topics surrounding sexuality, particularly in light of the fact that lead health education teachers consistently report supportive feedback from parents to expand, rather than limit, teaching in those areas.
- Schools should review their curricula, being cognizant of the fact that developmentally appropriate HIV/AIDS prevention education is required at every grade level by the Department of Elementary and Secondary Education through the Missouri School Improvement Program.

Introduction

The School Health Education Profile is a survey designed to monitor the status of health education in public schools, including education to prevent HIV infection and other important health problems, at the middle, junior, and senior high school levels. The survey is conducted in the spring of even-numbered years as a requirement of a cooperative agreement between the Missouri Department of Elementary and Secondary Education and the federal Centers for Disease Control and Prevention (CDC). The first administration of the survey in Missouri was in 1994.

Survey Methods

During the spring of 1998, questionnaires prepared by the CDC Division of Adolescent and School Health were sent to the principal and the lead health education teacher in 420 secondary schools. Systemic equal probability sampling with a random start was used to select schools from all regular secondary public schools having at least one of the grades 6 through 12. Usable questionnaires were received from 313 principals and 317 teachers.

The results from the questionnaires were weighted to permit generalization from the samples of 313 or 317 to the larger population of principals and lead health education teachers of schools with any of grades 6 through 12 in Missouri in the spring of 1998. The responses are representative of secondary principals and health education teachers in Missouri public schools, and results may be used to develop policies and improve programs for school health education.

Survey results were compiled in the following categories: (1) overall results for all schools, (2) middle school results for schools comprised primarily of grades 6 – 8, (3) junior/senior high school results for schools comprised primarily of grades 7 – 12, and (4) senior high school results for schools comprised primarily of grades 9 – 12. Not all data are reported in this publication. Key findings representing significant changes from the 1996 survey results are reported and discussed.

Acknowledgements

The Missouri Department of Elementary and Secondary Education extends sincere appreciation to Bill Datema, HIV Prevention Education Supervisor from 1992 through 1995, who administered the first school health education survey, and to Janet Wilson, HIV Prevention Education Supervisor from 1995 through 1998, who administered the surveys in 1996 and 1998. Because of their efforts, sufficient data have been collected to allow the results to be reported as representative of schools in Missouri and to build a foundation for the long-term monitoring of trends in health education in Missouri's public schools.

Additional thanks is extended to the CDC Division of Adolescent and School Health and to Westat, Inc. for the expertise and support they provided with data collection, analysis, and reporting.

Survey Results

School Support for Health Education

School administrators affect the quality of health education through policies that ensure health education occurs, that provide adequate training for teachers, and that build support through community involvement in shaping policies and curricula.

School administrators are responsible for ensuring that their schools meet minimum state requirements. The Missouri Department of Elementary and Secondary Education requires health education in all public schools, including, specifically, AIDS prevention education at every grade level. Twenty percent of the schools report not meeting this requirement.

Another standard of the Missouri School Improvement Program requires the adoption of a written policy on communicable diseases. The Department of Elementary and Secondary Education's *Policy Guidance on Communicable Diseases* (see Appendix C) includes guidelines for maintaining confidentiality, yet the percentage of schools with a written policy protecting the rights of students or staff with HIV infection or AIDS declined between 1996 and 1998.

The degree to which a professional trained in health education manages and coordinates a program is one measure of effective health education. Almost all schools now report having a designated health education coordinator.

Continuing education is another key indicator of the quality of school health education. Two of the measures of school support for continuing education lapsed nearly to the levels reported in the 1994 survey, with steep declines in the percentage of schools providing substitute teachers during training and reimbursing training expenses. However, the percentages of schools that provide stipends for training and offer in-service training on campus remained far above those of 1994 (see Table 1).

School health advisory councils not only elicit supportive attitudes from the community about health education, they also facilitate access to community resources. The percentage of schools with an active health education advisory council continued to decrease. On a positive note, among schools with a council, there was a statistically significant increase in the percentage reporting community representation on the council (9 percent in 1994, 39 percent in 1996, 71 percent in 1998).

Table 1. School support for health education, Missouri, 1998

	Percent of schools		
Years	*1994*	*1996*	*1998*
Require health education in any of grades 6 through 12	NA	84	80
Have written policy protecting rights of students and staff with HIV/AIDS	NA	78	72
Do not have health education coordinator	29	10	3
Have designated coordinator of health education	71	90	97
District superintendent	NA	6	3
District curriculum coordinator	21	6	18
School principal	NA	20	25
School curriculum coordinator	18	1	6
Health education teacher	NA	34	31
School nurse	NA	5	10
Other	16	18	4
Have school health advisory council	46	41	37
Provide stipend for teachers to attend training	19	34	30
Reimburse training expenses	52	74	58
Provide substitute teachers during training	58	84	61
Offer in-service training at school or district	49	66	61

NA – Not Available

Percent of lead health education teachers who taught about HIV infection and AIDS in any of grades 9 through 12

- in 1996: 100%
- in 1998: 95%

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Teacher Preparation

Effective health education is linked to teacher training and is aided by the use of teachers who have health education as a primary responsibility. Certification as a health educator typically requires specific training in college and mandates continuing education. Health education assignments and participation in continuing education may also indicate the school's level of support for health education.

Health education teachers in Missouri are well-qualified. However, since 1996, teachers have become slightly less experienced and less likely to be certified to teach health education. Eighty percent of the lead health education teachers were certified to teach health education in the grades they currently teach (87 percent in 1994, 90 percent in 1996). Fifty-six percent had been teaching health education for more than five years (87 percent in 1994, 61 percent in 1996). In light of these changes, school support for continuing education takes on added importance.

The primary teaching assignment of lead health education teachers was most frequently health *and* physical education, followed by family and consumer science and health education only (see Table 2).

Table 2. Teaching assignments and professional preparation of lead health education teachers, Missouri, 1998

	Percent of respondents		
Years	*1994*	*1996*	*1998*
Primary assignment of lead health education teachers			
Health education and physical education teacher	NA	46	41
Health education teacher	20	16	13
Physical education teacher	44	9	9
Science teacher	6	8	9
Home economics or family and consumer teacher	13	13	17
Family life education or life skills teacher	1	1	1
School nurse	3	1	4
Curriculum coordinator	NA	0	0
Other	11	8	6
Major emphasis of professional preparation			
Health and physical education	NA	40	42
Health education only	6	2	3
Physical education only	62	31	22
Science	6	4	5
Family life education or life skills education	15	14	14
Counseling	2	0	1
Nursing	4	2	5
Elementary Education	NA	4	6
Other	6	3	3

NA – Not Available

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Amount of Classroom Instruction

Although students' knowledge can be improved with approximately 10 hours of instruction, acquiring the skills needed to practice healthy behaviors requires approximately 40 to 50 hours of instruction each year for several consecutive school years.

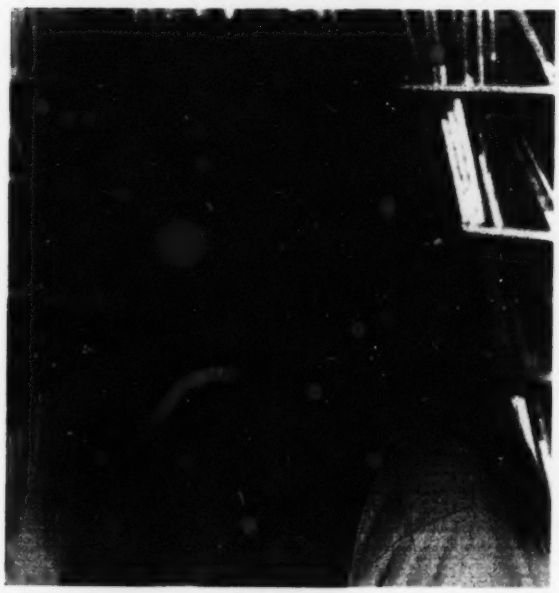
Paradoxically, although slightly fewer schools report that *any* health education is required (see Table 1), the great majority of schools that do require health education are requiring more (see Tables 3 and 4).

Table 3. Grades in which health education is required, Missouri, 1998

	Percent of schools		
Years	*1994*	*1996*	*1998*
6th	31	56	64
7th	52	76	78
8th	51	59	74
9th	27	49	61
10th	30	56	60
11th	9	24	32
12th	8	22	31

Table 4. Number of separate health education courses required in grades 6 – 12, Missouri, 1998

	Percent of schools		
Years	*1994*	*1996*	*1998*
None	33	18	10
1 course	50	44	48
2 courses	10	22	23
3 courses	4	13	15
4 courses	2	1	3



Percent of lead health education teachers who tried to increase student knowledge about pregnancy prevention

◆

in 1996:
76%

◆

in 1998:
84%

◆

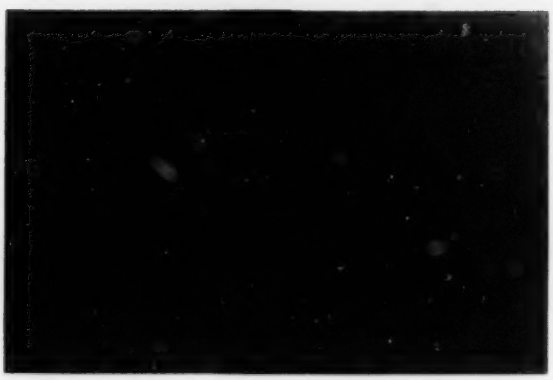
Content of Classroom Instruction

Research indicates that providing only factual information about health-related topics does not influence student behavior. A high percentage of teachers again reported teaching a variety of skills in health education courses (e.g., 96 percent decision making, 95 percent resisting social pressure for unhealthy behaviors, 76 percent analysis of media messages). Schools are to be commended for continuing to teach skills that prepare students to make responsible decisions about their health.

Research also indicates that involving students in decisions about programs and in presenting positive messages to their peers is an effective instructional tool. Peer educators may address attitudes and model behaviors in a manner that is more acceptable to students. The frequency with which schools report using trained peer educators to teach about health remains stable but low (28 percent in 1998, 29 percent in 1996).

The percentage of lead health education teachers who teach about HIV infection and AIDS as part of a required health education course in any of grades 6 through 12 declined from 96 percent in 1996 to 88 percent in 1998. There was a decrease in the amount of basic HIV/AIDS education, including biological facts about the disease, as well as such prevention topics as sexual behaviors that transmit HIV, condom use, and reasons for choosing sexual abstinence (see Table 5).

Issues most frequently cited as making it difficult to teach about HIV/AIDS were other demands on class time, inadequate or insufficient teaching materials, inadequate training, parental opposition, and community opposition (see Table 6).



Percent of lead health education teachers who taught reasons for choosing sexual abstinence

- in 1996: 96%
- in 1998: 92%

Table 5. HIV and AIDS topics taught in required health education courses in secondary schools, Missouri, 1998

	Percent of schools		
Years	*1994*	*1996*	*1998*
How HIV is and is not transmitted	NA	100	94
How HIV affects the immune system	NA	99	92
Disease progression of AIDS	NA	96	86
Needle-sharing behaviors that transmit HIV	75	99	92
Sexual behaviors that transmit HIV	78	98	91
Reasons for choosing sexual abstinence	74	96	92
Correct use of condoms	20	41	30
Condom efficiency	52	75	66
Influence of alcohol/drugs on HIV infection risk behaviors	68	91	87
Statistics on adolescent death and disability related to HIV infection/AIDS	NA	77	71
Group attitudes toward risk behaviors	41	84	77
Statistics on the risk behaviors	NA	81	73
Information on HIV testing and counseling	36	77	68
Compassion and support for persons with HIV/AIDS	33	77	67
Perceptions of risk for HIV infection/AIDS	41	92	85
Societal impact of HIV/AIDS	46	87	80

NA - Not Available

Table 6. Issues that make teaching about HIV/AIDS difficult for lead health education teachers, Missouri, 1998

	Percent of respondents		
Years	*1994*	*1996*	*1998*
Other demands on class time	30	41	38
Inadequate or insufficient teaching materials	20	32	30
Inadequate training	20	25	23
Parental opposition	14	18	21
Community opposition	12	12	18

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Parent and Community Involvement

The involvement of parents is necessary for successful health education. What is taught at school must be reinforced outside of the classroom if healthy behaviors are to be promoted and risky behaviors prevented. In addition, parents and communities are more supportive of health education if they know what is being taught and have the opportunity to influence what is taught.

Teachers and principals reported no significant changes in either their methods to involve parents in health education or in the kind of feedback parents gave. Teachers consistently report more feedback to expand health education, rather than limit it, even for controversial topics (see Table 9).

Table 7. Parental feedback to principals on health education, Missouri, 1998

	Percent of respondents		
Years	*1994*	*1996*	*1998*
No feedback received	48	50	46
Mainly positive feedback	45	45	46
Mainly negative feedback	2	0	1
Equally balanced between positive and negative feedback	5	5	7

Table 8. Strategies used to involve parents in health education courses, Missouri, 1998

	Percent of schools		
Years	*1994*	*1996*	*1998*
Sent educational materials to parents	28	49	43
Sent letters or newsletters on health education to parents	26	38	43
Provided school programs on health education for parents	NA	26	23
Invited parents to attend health education class	19	33	31

NA – Not Available

Table 9. Topics on which parental feedback caused lead health education teachers to expand or limit teaching, Missouri, 1998

Percent of respondents

Years	*1994*		*1996*		*1998*	
	expand	limit	expand	limit	expand	limit
Alcohol and other drug use prevention	13	0	33	1	23	1
Conflict resolution/violence prevention	6	0	23	0	17	1
HIV prevention	13	8	27	8	19	4
Human sexuality	NA	NA	21	11	13	10
Pregnancy prevention	14	13	21	11	13	9
Reproductive health	NA	NA	15	10	8	7
Sexually transmitted disease prevention	8	7	22	8	16	6
Suicide prevention	4	1	13	1	6	3
Tobacco use prevention	6	0	20	1	17	0

NA – Not Available

Percent of students in grades 9 through 12 who reported that they had ever talked about HIV infection and AIDS with an adult family member[1]

- in 1995: 64%
- in 1997: 58%

[1]Missouri Department of Elementary and Secondary Education. *Missouri Youth Risk Behavior Survey* (Jefferson City, Missouri: Missouri Department of Elementary and Secondary Education, 1996) 25

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Appendix A

Missouri School Improvement Standards on Health Education

Resource Standards[2]

Elementary School

1.1.1. Each elementary student will receive regular instruction in language arts, mathematics, science, social studies, comprehensive health (including tobacco, alcohol and other drug prevention and HIV/AIDS prevention education) and career education.

Junior High/Middle School

1.2.2. Physical education is scheduled and taught to all students for a minimum of 3,000 minutes each year and health (including tobacco, alcohol and other drug abuse prevention education and HIV/AIDS prevention education) and safety education is scheduled and taught to all students for a minimum of 1,500 minutes each year.

High School

1.3 Each high school has a current minimum offering of at least 40.5 units of credit, with sufficient sections in each course to meet the needs of all students in grades 9 – 12 and the state high school graduation requirements. These courses are distributed as follows:

	MINIMUM STANDARD	DESIRABLE STANDARD
Health (Includes tobacco, alcohol and other drug prevention and HIV/AIDS prevention education)	0.5	1.0

Missouri School Improvement Standards on Communicable Diseases

Process Standards[3]

15.1.2. The school health services program includes a policy on administration of medication, as well as specific provisions for complying with all board policies, statutes and regulations regarding contagious and infectious diseases, immunization of schoolchildren and child abuse reporting.

15.1.5. Cumulative health records, including immunizations as required by statute, are maintained and regularly updated for all students. Confidentiality of health records is protected by district policy.

[2]Missouri Department of Elementary and Secondary Education. *Missouri School Improvement Program Standards and Indicators Manual*. 1997: 5.6.8.
[3]Ibid., 39.

Appendix B

Policy Guidance on Communicable Diseases

The continuing expansion of medical knowledge about communicable diseases and expanding statutory and case law on the rights of individuals who may have the diseases make it imperative that local boards of education routinely review their policies and procedures for dealing with communicable diseases to be sure they are both legal and effective.

The State Board of Education periodically reviews and updates its policy guidance on communicable diseases and distributes the revised documents to public schools. The policy guidance was last revised in September 1990. It consists of two parts: Communicable Disease-Student and Communicable Disease-Employee. Throughout the document, reference is made to Infection Control Procedures for Schools. These guidelines, published by the Missouri Department of Health, are attached to this document.

The State Board of Education recommends that all local boards of education review their policies and procedures and make adjustments where necessary.

This policy guidance was approved by the Missouri State Board of Education in October 1987 and revised in October 1988, June 1989, September 1990 and November 1995.

Communicable Disease – Student

Purpose

The School Board recognizes its responsibility to protect the health of students and employees from the risks posed by infectious diseases. The Board also has the responsibility to uphold the rights of affected individuals to privacy and confidentiality, to attend school and to be treated in a nondiscriminatory manner.

Immunization

Students cannot enroll and/or attend school unless immunized as required by Missouri law.

Universal Precautions

The district requires all staff to routinely observe universal precautions to prevent exposure to disease-causing organisms, and the district should provide necessary equipment/supplies to implement universal precautions (see Appendix C).

Categories of Potential Risk

Students with infectious diseases that can be transmissible in school and/or athletic settings (such as, but not limited to, chicken pox, influenza and conjunctivitis) should be managed as specified in: (a) the most current edition of the Missouri Department of Health document entitled: *Prevention and Control of Communicable Diseases: A Guide for School Administrators, Nurses, Teachers, and Day Care Operators* and (b) documents referenced in 19 CSR 20-20.030 and (c) in accordance with any specific guidelines/recommendations or requirements promulgated by the local county or city health department.

A student infected with a bloodborne pathogen such as hepatitis B virus (HBV), hepatitis C virus (HCV), or human immunodeficiency virus (HIV) poses no risk of transmission through casual contact to other persons in a school setting. Students infected with one of these viruses shall be allowed to attend school without any restrictions which are based solely on the infection. The district cannot require any medical evaluations or tests for such diseases.

> Exceptional Situations: There are certain specific types of behaviors (for example, biting or scratching) or conditions (for example, frequent bleeding episodes or uncoverable, oozing skin lesions) which could potentially be associated with transmission of both bloodborne, and non-bloodborne pathogens. No student, regardless of whether he or she is known to be infected with such pathogens, should be allowed to attend school unless these behaviors or conditions are either absent or appropriately controlled in a way that avoids unnecessary exposure.

In these exceptional instances, an alternative educational setting may be warranted. In certain instances, a desig-

nated school administrator may want to convene a Review Committee. The number of persons on the Review Committee should be limited. It is recommended that members be limited to: 1) the parent(s)/guardian(s), 2) medical personnel (student's physician, school nurse) 3) building administrator, 4) superintendent and/or designee. Local health department officials may be consulted and/or included as members of the review team. If the student is identified as having a disability, any change of placement would need to be effected through the Individualized Education Program (IEP) process. In the case of a student who is disabled, but not identified under the Individuals with Disabilities Education Act, any change of placement would need to be effected through a multidisciplinary team meeting.

Specific mechanisms should be in place to ensure the following are consistently done:

a. All episodes of biting, and all children who exhibit repeated instances of significant aggressive behavior, should be reported to the designated school administrator.

b. The school nurse, and the designated school administrator when appropriate, should be informed of any child who has recurrent episodes of bleeding or who has uncoverable, oozing skin lesions.

c. The school nurse, and the designated school administrator, when appropriate, should be promptly informed of any child with an illness characterized by a rash.

d. The school nurse and designated school administrator shall be informed promptly of any instance in which the significant potential for disease transmission occurs.

Confidentiality
The superintendent or designee shall ensure that student confidentiality rights are strictly observed in accordance with law. Missouri law (§191.689 RSMo. (1994)) identified two groups of people within a school system who could be informed of the identity of a student with HIV infection on a "need to know" basis. They are:

1. Those designated by the school district to determine the fitness of an individual to attend school (see recommended Review Committee membership listed above); and

2. Those who have a reasonable need to know the identity of the child in order to provide proper health care.

Examples of people who need to know are: school nurse, review team members, and IEP team if applicable. Security of medical records will be maintained. Breach of confidentiality may result in disciplinary action, a civil suit, and/or violation of the Family Educational Rights and Privacy Act.

Education – Student
All students should receive age-appropriate information about the prevention and control of communicable diseases, to include the use of universal precautions. Instruction should be incorporated within a comprehensive school health curriculum in grades K – 12 as stated in Missouri School Improvement Program Standards.

Reporting and Disease Outbreak Control
Reporting and disease outbreak control measures will be implemented in accordance with state and local laws and Department of Health rules governing the control of communicable and other diseases dangerous to public health, and any applicable rules promulgated by the appropriate county or city health department.

Notification
Superintendents who supply a copy of a board-approved policy that contains provisions substantially similar to this guideline to the Department of Health shall be entitled to confidential notice of the identity of any district child reported to the Department as HIV-infected and known to be enrolled in the district (whether in a public or private school). The parent or guardian is also required by law to provide such notice to the superintendent.

Review
Districts should periodically review their policies and procedures and make revisions when necessary.

Approved:

Legal Refs: §167.191, 191.650-.703 RSMo.
Americans with Disabilities Act
(42 U.S.C. 12101 et seq.)
P.L. 94-142 Individuals with Disabilities Education Act of 1973 (20 U.S.C. 1400 et seq.)
P.L. 92-112, Section 504 of the Rehabilitation Act of 1973
19 CSR 20.20.010 – 20.20.060 and 20.28.010

Communicable Disease – Employee

Purpose
The School Board recognizes its responsibility to protect the health of students and employees from the risks posed by infectious diseases. The Board also has the responsibility to uphold the rights of affected individuals to privacy and confidentiality, to continue their employment, and to be treated in a nondiscriminatory manner.

Universal Precautions
The district requires all staff to routinely observe universal precautions to prevent exposure to disease-causing organisms, and the district should provide necessary equipment/supplies to implement universal precautions (see attachment).

Categories of Potential Risk
Employees with infectious diseases that can be transmissible in school and/or athletic settings (such as, but not limited to, chicken pox, influenza and conjunctivitis) should be managed as specified in: (a) the most current edition of the Missouri Department of Health document entitled: *Prevention and Control of Communicable Diseases: A Guide for School Administrators, Nurses, Teachers, and Day Care Operators* and (b) documents referenced in 19 CSR 20-20.030 and (c) in accordance with any specific guidelines/recommendations or requirements promulgated by the local county or city health department. A medical release may be required of the employee in certain circumstances.

An employee infected with a bloodborne pathogen such as hepatitis B virus (HBV), hepatitis C virus (HCV), or human immunodeficiency virus (HIV) poses no risk of transmission through casual contact to other persons in a school setting. Employees infected with one of these viruses shall be allowed to continue work without any restrictions which are based solely on the infection.

Exceptional Situations: There are certain specific conditions (for example, frequent bleeding episodes or uncoverable, oozing skin lesions) which could potentially be associated with transmission of both bloodborne, and non-bloodborne pathogens. No employee, regardless of whether he or she is known to be infected with such pathogens, should be allowed to continue work unless these conditions are either absent or appropriately controlled in a way that avoids unnecessary exposure.

Specific mechanisms should be in place to ensure the following are consistently done:

a. The school nurse, and the designated school administrator, when appropriate, should be informed of any staff member who has recurrent episodes of bleeding or who has uncoverable, oozing skin lesions.

b. The school nurse, and the designated school administrator, when appropriate, should be promptly informed of any employee with an illness characterized by a rash.

c. The school nurse and the designated school administrator shall be informed of any instance in which the significant potential for disease transmission occurs.

Confidentiality
The superintendent or designee shall ensure that an employee's confidentiality rights are strictly observed in accordance with law. Security of medical records will be maintained and such records will be kept separate from other personnel records. Breach of confidentiality may result in disciplinary action and/or civil suit.

Training – Employee
All employees should receive training annually on universal precautions and the Communicable Disease Policy.

Testing – Employee
Requiring medical evaluations or tests of employees will not normally be authorized under the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act. Schools may require post-offer, preemployment or annual physical examinations if the exam is job-related and if conducted on all employees or applicants for similar positions. Requiring medical evaluations or tests for infection with bloodborne pathogens is not allowed by law.

Reasonable Accommodations
Districts should develop procedures to respond to employee requests for reasonable accommodations when an employee has a disability as defined by Section 504 and/or the ADA.

Reporting and Disease Outbreak Control
Reporting and disease outbreak control measures will be implemented in accordance with state and local laws and Department of Health rules governing the control of communicable and other diseases dangerous to public health, and any applicable rules promulgated by the appropriate county or city health department.

Review
Districts should periodically review their policies and procedures and make revisions when necessary.

Approved:

Legal Refs: §167.191, 191.650-.703 RSMo.
Americans with Disabilities Act
(42 U.S.C. 12101 et seq.)
P.L. 93-112, Section 504 of the Rehabilitation Act of 1973
19 CSR 20.20.010 - 20.20.060 and 20.28.010

Appendix C

Infection Control Procedures for Schools

General Procedures For Preventing Transmission of Infectious Diseases in School Settings

Having direct contact with the body fluids of another person can potentially provide the means by which many different infectious diseases can spread. Some examples of body fluids which can transmit infection, and some of the diseases that can result, are the following:

Body Fluid	Diseases Spread Through Contact With This Body Fluid
Eye discharge	Conjunctivitis (Pink Eye)
Nose or throat discharge	Colds, Influenza
Blood	Hepatitis B, HIV disease
Feces	Hepatitis A, shigellosis, giardiasis
Urine	Cytomegalovirus infection

It is important to remember that any person could potentially have disease-causing organisms in their body fluids, even if they have no signs or symptoms of illness. Consequently, the following recommendations should be followed in all situations, and not just those involving an individual known to have an infectious disease.

In the school setting, it is recommended that reasonable steps be taken to prevent individuals from having direct skin or mucous membrane* contact with any moist body fluid from another person. Specifically, direct contact should be avoided with all of the following:

1. blood (preventing exposure to blood or blood-contaminated body fluids is discussed in more detail in the following section on universal precautions)
2. all other body fluids, secretions, and excretions regardless of whether or not they contain visible blood
3. nonintact skin (any area where the skin surface is not intact, such as moist skin sores, ulcers, or open cuts in the skin)
4. mucous membranes

If hands or other skin surfaces are contaminated with body fluids from another person, washing with soap and water should take place as soon as possible.

In general, standard medical vinyl or latex gloves should be worn whenever the possibility of direct contact with any body fluid from another person is anticipated. Gloves should be available and easily accessible in any setting where contact with body fluids could take place. Hands should always be washed immediately after removal of gloves. Pocket masks or other devices for mouth-to-mouth resuscitation should be available.

Additional steps to reduce the risk of transmission of communicable diseases in the school setting include the following:

1. Toilet tissue, liquid soap dispensers, and disposable towels should always be available in all restrooms. All children should be taught proper handwashing and encouraged to practice this after using the restroom.
2. All children should wash their hands, with direct supervision as necessary, before eating.
3. Children should be discouraged from sharing food, personal grooming items, and cosmetics.
4. Younger children should be discouraged from placing other's fingers in their mouths or their own fingers in the mouths of others, and from mouthing objects that others might use.
5. Proper sanitation procedures must be followed with regard to food handling and preparation, control of insects and rodents, and proper disposal of solid waste.

Universal Precautions

The strategy of universal precautions was developed in the mid-1980s as a means of preventing the transmission of bloodborne pathogens such as human immunodeficiency virus (HIV) and hepatitis B virus (HBV). Although universal precautions were initially designed for use in hospitals and clinics, they are applicable to any workplace setting, including schools, where exposure to blood or blood-contaminated materials could potentially occur.

Universal precautions apply only to blood, body fluids which are visibly contaminated with blood, and certain other body fluids such as semen, vaginal secretions, amniotic fluid, and cerebrospinal fluid. These precautions are designed specifically to prevent direct skin or mucous membrane exposure to these particular fluids, as well as to prevent accidents involving sharp instruments (such as

*Mucous membranes cover the eyes and the inside of the nose and mouth, along with certain other parts of the body. In a school setting, avoiding mucous membrane contact with body fluids means, for practical purposes, that one does not get these fluids in one's eyes, nose, or mouth. This can generally be accomplished by not rubbing the eyes with one's hands, and not putting the hands or anything touched by unwashed hands (such as food) in one's mouth. Good handwashing is vital to preventing mucous membrane exposure to disease-causing organisms.

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needles) contaminated with these fluids. The term "universal" indicates that these precautions should be taken at all times and in all situations.

Universal precautions involve the following measures:

1. Appropriate barrier precautions should be used to avoid skin or mucous membrane contact with any of the above-mentioned body fluids. Such barrier precautions can, based on the given situation, include the use of standard medical vinyl or latex gloves along with gowns, protective eyeware, and/or masks. If potential contact with a significant amount of blood is anticipated, latex gloves are preferred. These items should always be available and readily accessible.
2. Hands and other skin surfaces should be washed immediately and thoroughly if contaminated. Hands should always be washed immediately after gloves are removed.
3. If any of the above-mentioned body fluids come into contact with the mucous membrane surfaces of the nose or mouth, the area should be vigorously flushed with water. If the mucous membrane surfaces of the eyes are contaminated, there should be irrigation with clean water, or with saline solution or sterile irrigants designed for this purpose.
4. Precautions should be taken to avoid injuries with sharp instruments contaminated with blood. Needles should not be recapped, purposely bent or broken by hand, removed from disposable syringes, or otherwise manipulated by hand. After they are used, disposable syringes and needles, and other sharp items, should be placed in puncture-resistant, leak-proof containers for disposal; the puncture-resistant containers should be located as close as practical to the use area.
5. Persons providing health care who have exudative skin lesions or weeping dermatitis should refrain from all direct patient care, and from handling patient-care equipment, until the condition resolves.

Persons who, as part of their assigned occupational duties, may reasonably be expected to have contact with blood should be vaccinated with hepatitis B vaccine. Vaccination of all school staff is neither feasible nor necessary. However, certain staff are assigned duties which could place them at increased risk of infection with hepatitis B. These individuals should be provided, free of charge, three doses of hepatitis B vaccine. Such individuals include:

1. the person(s) assigned primary responsibility for providing first aid
2. special education/early childhood development personnel who have contact with hepatitis B-infected children. These children may have special behavioral and/or medical problems which increase the likelihood of hepatitis B transmission
3. the person(s) assigned primary responsibility for cleaning up body fluid spills

A person who has been offered hepatitis B vaccine but refuses to receive it should be required to sign a statement indicating the vaccine was offered but he/she chose not to be vaccinated.

The Occupational Safety and Health Administration (OSHA) bloodborne pathogens rule 29 CFR Part 1910.1030 does not apply to public schools or other public institutions in Missouri. However, this rule establishes the current standard of practice with regard to the prevention of transmission of infectious bloodborne agents in occupational settings, and it contains good public health and risk management policies. School administrators and other school personnel who are involved in making health policy decisions should become familiar with this rule and consider, in consultation with appropriate legal counsel, adopting the policies which it describes, including the development of an exposure control plan. Such an exposure control plan should contain a statement on providing hepatitis B vaccine to appropriate school staff.

School nurses (RNs and LPNs) licensed under Chapter 335, RSMo, are required, according to 191.694, RSMo, to adhere to universal precautions, including the appropriate use of hand washing, protective barriers, and care in the use and disposal of needles and other sharp instruments.

Body fluids which are not associated with transmission of bloodborne pathogens, such as tears, nasal secretions, saliva, urine, and feces, are not covered by universal precautions. However, since these body fluids can transmit other diseases, the recommendations in the preceding section, which state that direct contact with these materials is to be avoided, should be followed at all times. Put another way, the use of universal precautions does not eliminate the need to utilize good infection control practices, including careful attention to handwashing, in all situations, regardless of whether there is risk of exposure to blood.

Procedures for Cleaning Spills of Blood or Other Body Fluids

1.Absorbent floor-sweeping material should be used to cover larger body fluid spills.

2. Wear sturdy, non-permeable gloves and other protective clothing as necessary

3. Use disposable absorbent towels or tissues, along with soap and water, to clean the area of the spill as thoroughly as possible.

4. All surfaces that have been in contact with the body fluids should then be wiped with a disinfectant. Any EPA-approved tuberculocidal disinfectant can be used. A 1:10 dilution of household bleach can also be used (this solution should not be mixed in advance because it loses its potency). After the disinfectant is applied, the surface should either be allowed to air dry, or else to remain wet for 10 minutes before being dried with a disposable towel or tissue.

5. If the gloves worn to clean up the spill are reusable rubber gloves, they should be washed with soap and running water prior to removal. Disposable gloves should be placed in an impermeable plastic bag. Regardless of the type of gloves used, care should be taken during glove removal to avoid contamination of the hands. However, whether or not any known contamination occurs, the hands should always be thoroughly washed with soap and water after the gloves are removed.

6. If the person doing the cleanup has any open skin lesions, precautions should be taken to avoid direct exposure of the lesions to the body fluids.

7. If direct skin exposure to body fluids accidentally occurs, the exposed area should be thoroughly washed with soap and water for at least 15 seconds.

8. It is necessary to keep one or more cleanup kits on hand for blood/body fluid spills. The cleanup kit should consist of the following items:

- Absorbent floor-sweeping material
- Liquid soap
- Disinfectant
- Small buckets
- Rubber or plastic gloves
- Disposable towels or tissues
- Impermeable plastic bags

All of these materials should be kept together in one or more central locations so that they are easily accessible.

CAUTION: Diluted bleach disinfectant solution, if utilized, should not be used for any other purpose than the cleanup described above. Mixing this solution with certain other chemicals can produce a toxic gas. Also, any EPA-approved disinfectant that is used should be diluted according to manufacturer's instructions. It is not appropriate or necessary to add more disinfectant than the directions indicate. Doing so will make the disinfectant more toxic, and could result in skin or lung damage to those individuals using it.

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